MMSO DENTAL INFORMATION SHEET

1. Patient's Name:	2. Pay Grade	3. Social Security No:	4. Birth date:	5. Date Filed:

6. Current Duty/Unit Address:

_____ _____
Command/Unit UIC/ OPFAC

_____
Street Address

_____ _____ _____
City State Zip Code

_____
Duty/Unit phone number (with area code)

7. Patient's Home Address:

_____
Street Address

_____ _____ _____
City State Zip Code

_____
Home phone number (with area code)

8. Branch Of Service:

USA_____ USN_____ USMC_____ USAF_____ *USAR_____ *USNR_____ * USMCR____*****USAFR_____

Army NG (Active)_____ *Army NG (Inactive)_____ Air NG (Active)_____ *Air NG (Inactive)____

Other_____ Please explain: _____

*** If Reserve or Guard, Type of LOD: [ ] ADMIN [ ] INFORMAL [ ] FORMAL**

9. Type of Care:

Emergency Care_____ Routine_____ Pre-Authorization Yes_____ No_____

If Yes, Pre-Authorization number:_____

* When treatment was received member (If NOT Active Duty) was on: [ ] IDT [ ] ADT [ ] AT [ ] ADSW

10. Did a Military Dental Clinic authorize the referral of this care? Yes_____ No_____

If so, Name and location of referring dental Clinic: _____
(Include a copy of the DD-2161 Referral for Civilian Medical Care form)

11. Name of- Civilian Dentist	Treatment Dates	Charges

12. Have bills been paid? Yes____ No____ If yes, In full_____ In Part_____

If yes, By whom_____

If member paid, submit the itemized bill(s), a SF 1164 (Claim for Reimbursement with the member's original signature), and proof of payment (front and back of canceled check, receipt, or itemized bill showing a zero balance).

13. Signature of patient or the person who is authorizing the release of health care records related to this injury/illness to MMSO. Signature validates information provided.

_____ _____
Signature Date signed

I certify that this individual is eligible for care at government expense

_____ _____ _____ _____
Signature Printed name (CO or Medical representative) Phone Date

MMSO DENTAL INFORMATION SHEET

1. **Purpose:** This information sheet is used by eligible members of the U.S. Navy, Army, Air Force, Marine Corps, Army and Air National Guard, including reservists (on active duty or in training) to request payment or reimbursement for **dental services** provided by a civilian healthcare provider.

2. **When to file:**. Submit claims immediately after treatment. Claims returned to the unit or member for additional information must be submitted within 15 days or they will be closed. Closed claims may be reopened for consideration on a case-by-case basis**. Delay in submitting claims could affect the members' credit rating.**

3. **Who fills out the sheet:** Patients are responsible for completing the MMSO Dental Information sheet. For assistance, contact your medical representative. If the patient or MEDREP need further assistance, contact our Customer Service Department at **DSN 792-3950**, or call us toll free at **1-888-647-6676**. For a copy of this sheet visit our website at **http://mmso,med.navy.mil**

4. **What documents must you provide?** Send the original Dental Information Sheet and itemized bills. Balance due statements are not acceptable. Bills submitted on provider's letterhead must contain:

   a. Providers name, address, and providers' tax identification number
   b. Patient's name, social security number and date of birth
   c. Date services or supplies were provided
   d. Description of each service or supply
   e. Charge for each service or supply.

1. **What information must be provided?** Answer each item. If the information requested does not apply to the patient, indicate N/A (not applicable). An incomplete information sheet will cause delays in processing and payment of your bill.

2. **How a member gets reimbursed (SF 1164)?** If payment was made directly to the Healthcare provider by the patient or representative, the patient must submit a Claim for Reimbursement for Expenditures on Official Business (SF 1164). Include the itemized bill and proof of payment (front and back or canceled check, receipt, or itemized bill showing a zero balance). Members' original signature must be in block 10 of the SF 1164 form.

3. **Who must sign the MMSO Dental Information Sheet?** The patient and authorized person (medical representative, health benefit advisor, or senior officer). The signature validates the MMSO Dental Information Sheet, and ensures that the patient's health record reflects the civilian dental treatment received.

4. **Where to file the claim**. Submit completed MMSO information sheet with itemized bills and any supporting documentation to: **OFFICER IN CHARGE, MILMEDSUPPOFF, PO BOX 886999, GREAT LAKES IL 60088-6999.**

Privacy Act Statement

Sections 6201, 6202, and 6203 of title 10 to U.S. Code authorized collection of this information. The purpose of this information is to evaluate eligibility for civilian health benefit and to issue payment upon verification of eligibility. MILMEDSUPPOFF uses the information to process health care claims for payment; for review of claims related to possible third party liability cases and initiation of recovery actions; for referral to professional review organizations to control and review providers dental care; for disclose to third party contacts without the consent of the individual, to respond to inquiries from congressional offices made at the request of the covered individual; and for medical boards. Information must be provided if you expect to have the claim paid by the Government. Failure to provide information will result in denial or delay in payment of the claim.